Sample Coronavirus COVID-19 Screening Questionnaire

Name:

Date:

Job title/position:

In the last 14 days have you traveled outside your normal, daily routine? YES/ NO

Do you have new or worsening onset of any of the following symptoms: fever, cough, shortness of breath, runny nose, sore throat, chills, body aches, fatigue, headache, loss of taste/smell, eye drainage, congestion? YES/ NO

If "Yes " to the above question, please list symptoms below:

_____
_____
_____

Was your temperature over 100.4º F or 38º C before coming to work today? YES/NO

Have you been exposed to someone being tested for COVID-19 or who has symptoms compatible with COVID-19? YES/ NO

Are any members of your household or a close contact in quarantine for exposure to COVID-19? YES/NO

If you have answered "Yes" to any of these questions:

• Please remain home or leave premise of your work location - contact your immediate supervisor

• Call the corporate headquarters at ___- ___ - ____ between the hours of 6:30 a.m. and 7 p.m.

• If outside these hours, contact your manager, remain at or return home.

I understand that I have the responsibility to immediately notify corporate headquarters AND my immediate supervisor should my responses on this questionnaire change.

_____
Signature